STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 00 B. WING	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00443579. Complaint IN00443579 - Federal/state deficiencies related to the allegations are cited at F554, F692, F726, F755, F761, and F880 . Survey dates: October 9 and 10, 2024. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 4 Medicaid: 46 Other: 28 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 21, 2024.	F 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Eagle Valley Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure medication was not left at bedside without a self-medication assessment for 1 of 1 resident reviewed for medication self-administration (Resident B).	F 0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B has a self-medication assessment completed for	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	11/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: On 10/10/24 at 10:16 a.m., Ventolin (albuterol) and Symbicort inhalers were observed on Resident B's over the bed table. On 10/10/24 at 11:24 a.m., Resident B's self-administration assessment was reviewed. It indicated on 9/5/24, she was approved to self-administer bacitracin (topical antibiotic) to her nose. No other medications were listed to self-administer. A current policy, titled, "General Dose Preparation and Medication Administration," dated 4/30/24, was provided by the DON, on 10/10/24 at 11:30 a.m., a review of the policy indicated, " ...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ...." This citation relates to Complaint IN00443579. 3.1-11		inhalers and creams approved by the physician and IDT team. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that choose to self-administer medications have the potential to be affected by the alleged deficient practice. A 1x audit completed by DNS/designee of all residents that self-administer medications to ensure an assessment is completed and approved by the physician and IDT team. An in-service has been completed by DNS/designee on or before 10/31/24 regarding Medication Self-Administration Policy. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? An in-service has been completed by DNS/designee on or before 10/31/24 regarding Medication Self-Administration Policy. Any resident that self-administers medication will be reviewed by the IDT quarterly or with significant change of condition to determine continued ability to self-administer medication. How be monitored to ensure the deficient practice will not recur,	

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			i.e., what quality assurance program will be put into place? The DNS/Designee will be responsible for the completion of the Medication Storage / Self Medication Administration / Medication Administration and Prep Review CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident B) was comprehensively assessed for her nutritional status and person centered interventions were implemented for 1 of 3 residents reviewed for nutrition. Findings include: During an interview on 10/9/24 at 11:36 a.m., Resident B indicated, she did not like the food and was tired of only being able to receive hamburgers as food substitutes. She was supposed to be on a low sodium diet, but did not feel like she had been	F 0692	p="" paraid="374782831" paraeid="{a43086c5-4c62-48a4-b90b-60b8f1073428}{175}"> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B is receiving a low sodium diet per resident preference and MD orders. Resident B nutritional care plan has been updated to reflect current nutritional management.	11/01/2024

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	provided with a variety of options or healthier options. Resident B indicated when she asked for alternative food options, staff told her the alterative menu would also be a hamburger. Resident B indicated she had never been visited by the Registered Dietician (RD). She wanted the RD to see her, review her new low sodium diet, and give more options than just a hamburger. On 10/9/24 at 1:11 p.m., Resident B's lunch tray was observed, and the meal had been consumed. Resident B pointed to her ticket which indicated she received a hamburger again. She indicated she ate it because she was hungry and when she asked about an alternative the nurse said it might be a while before she could get anything else. On 10/9/24 at 11:40 a.m., Resident B's medical record was reviewed. She was a long-term care resident who had diagnoses which included but not limited to, acute on chronic congestive heart failure, type II diabetes mellitus and anxiety. An admission Minimum Data Set (MDS) assessment, dated 8/18/24, indicated Resident B was cognitively intact. Her nutrition assessment, section K, was completed by the MDS Coordinator (MDSC) on 8/15/24. Section K indicated Resident B's height and weight, but weight gain and/or weight loss was listed as "unknown." An admission Initial Nutrition Review, dated 8/12/24, was completed by the Culinary Dietary Manager (CDM). The Nutrition Review indicated, Resident B received a regular diet, and disliked pork and salty foods. Resident B's goal for nutritional health was, "healthy heart diet." Resident B's record lacked documentation that a		Resident B has a Nutrition Focused Physical Exam (NFPE) completed by Registered Dietician **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practices. 1x audit was completed for residents to ensure a NFPE has been completed by the RD 1x audit was completed to ensure resident dietary preferences are being honored and care plans updated as needed. Regional Dietitian conducted an in-service with DNS, RD, and nurse managers on or before 10/31/24 regarding resident nutritional assessments and dietary preferences. Staff in-service conducted by ED/designee on or before 10/31/24 regarding resident dietary preferences and offering alternative meal options. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Regional Dietitian conducted an in-service with DNS, RD, and nurse managers on or before	

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	Nutrition Focused Physical Exam (NFPE) and/or a Estimated Nutrient Needs Assessment had been completed. A nursing progress note, dated 9/28/24 at 1:07 a.m., indicated, Resident B had complained of chest pain and was sent to the Emergency Department (ED). A corresponding hospital discharge summary, dated 10/1/24, indicated Resident B presented to the ED with complaints of chest pain and trouble breathing. " ...diet is high salt as she cannot be on a heart healthy diet at her facility ... patient was evaluated by medical nutrition and educated on a low salt diet and weight loss strategies. Patient's presentation was thought to be in part due to high sodium intake from diet ... Barriers to care: availability of low salt diet ... Active issues requiring follow-up: Acute on chronic heart failure ... needs to be on a low salt diet to prevent exacerbation of heart failure ...." Resident B's current physician's orders were reviewed, and she had a Regular Diet order dated 8/7/24 with no specifications of low-salt. Resident B's comprehensive care plans were reviewed. She had a care plan initiated 8/13/24 which indicated she was at risk for unintentional weight loss, but that weight loss would be warranted. Interventions included, but were not limited to monitor her weight, notify doctor of weight changes and provide diet per doctor's orders. Resident B's care plans lacked documentation of revisions to address what kind of weight loss may be warranted, goals for weight loss, preferences		10/31/24 regarding resident nutritional assessments and dietary preferences. Staff in-service conducted by ED/designee on or before 10/31/24 regarding resident dietary preferences and offering alternative meal options A NFPE will be completed by the Registered Dietician upon admission and additionally at the RD's clinical discretion RD/designee will complete the Estimated Nutrient Needs observation following admission and with each comprehensive assessment, but no less than annually RD/designee will assess resident dietary preferences upon admission **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DNS/Designee will be responsible for the completion of the Nutrition Assessment CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be	

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	for a low salt diet and or interventions to address known behaviors related to her nutrition management. Resident B's weight was obtained upon admission on 8/7/24 but had not been taken since. During an interview on 10/9/24 at 1:57 p.m., the Regional Registered Dietician Consultant (RRDC) indicated, upon admission, a resident should be seen by the CDM within the first business day to obtain diet orders and preferences. After admission, but within 14 days, the resident should be assessed and evaluated by the RD. The RRDC reviewed Resident B's MDS and nutritional assessments and indicated, it appeared that the RD had not been to see Resident B since her admission. The MDS should trigger the comprehensive care plan, and additional revisions would have been made after the RD assessed the resident. On 10/9/24 at 2:40 p.m., the Director of Nursing Services (DNS) provided a copy of current facility policy title, "Nutrition Review and Assessment," revised 9/2024. The policy indicated, " ...It is the policy of American Senior Communities that each resident and/or family will be interviewed to determine preferences surrounding meals as well as to assess nutrition status and factors that may pout the resident at risk for altered nutrition ... A Nutritional Focused Physical Exam (NFPE) will be completed by the Registered Dietician upon admission and additionally at the RD's clinical discretion. The NFPE is used to assess the resident for fat and/or muscle wasting to determine nutritional status and to assist in developing an appropriate nutrition plan of care ... The RD, or designee will complete the Estimated Nutrient Needs observation following admission		developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	

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	and with each comprehensive assessment but, no less that annually ... Information from the Initial Nutrition Review, Malnutrition Screening Tool, Estimated Nutrient Needs, Nutritional Focused Physical Exam, interviews with the resident ... will all be used to complete the ... Resident centered care plan and to update the tray ticket system ...." This citation relates to Complaint IN00443579. 3.1-46			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on observation, interview, and record review, the facility failed to ensure staff were competent with medication administration for 2 of 2 residents observed for medication administration (Residents B and E) Findings include: On 10/10 24 at 10:09 a.m., LPN 8 was observed at the B Hall Medication Cart. During a medication administration for Resident B, LPN 8 provided a Symbicort inhaler (treats asthma and COPD-chronic obstructive pulmonary disease), the resident took a puff of the inhaler. Immediately after, LPN 8 provided albuterol (treats asthma and COPD) and Spirva (dilates bronchial passage ways) with no delay between puffs. He provided water for the resident to rinse her mouth. She swallowed the water. On 10/10/24 at 10:35 a.m., LPN 8 was observed preparing medication for Resident E. He was observed pouring 15 mL (milliliters) Robitussin (cough suppressant) into a medication cup. He	F 0726	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B and E are receiving medications as prescribed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. A 1x medication pass skills validation has been completed for nursing staff DNS/Designee conducted an in-service with nursing staff by 10/31/24 regarding proper medication preparation and administration	11/01/2024

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	was observed lifting the round cardboard from the touch of the bottle with his bare fingers. He double checked the level of medication at eye-level and indicated 15 mL. The physician's order indicated the resident received 10 mL Robitussin. On 10/10/24 at 10:39 a.m., LPN 8 started to provide the 15 mL to Resident E. He was asked to confer in the hallway. He insisted the medication was at 10 mL until he removed his cell phone and used the flashlight to illuminate the markings on the side of the medication cup. Afterward, he indicated he needed readers (magnifying glasses). The correct amount of Robitussin was provided to the resident. A current policy, titled, "General Dose Preparation and Medication Administration," dated 4/30/24, was provided by the DON, on 10/10/24 at 11:30 a.m., A review of the policy indicated, " ...Medications should not come in contact with any surface except for the medication cup ...Facility staff should avoid touching the medication with bare hands when opening a bottle ...Facility staff should verify that the medication name an dose are correct when compared to the medication order on the medication administration record ...." This citation relates to Complaint IN00443579. 3.1-14(k)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/Designee conducted an in-service with nursing staff by 10/31/24 regarding general dose preparation and medication administration Daily observational rounds to be conducted by DNS/designee to ensure medications preparation and administration are being followed per policy **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Designee will be responsible for the completion of the Medication Storage / Self Medication Administration / Medication Administration and Prep Review CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or	

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			including termination of the responsible employee.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure medications were provided according to the physician's order (Resident B) for 1 of 2 residents reviewed for medication administration. Findings include: On 10/10/24 at 9:45 a.m., Resident B expressed concern about missing some of her medications. She indicated she missed her clonazepam (antianxiety) four times this week. On 10/10/24 at 11:24 a.m., Resident B's October Medication Administration Record (MAR) was reviewed for missing medications. According to the MAR: a. Her clonazepam 1 mg, a scheduled IV tablet (controlled substance), was not given on 10/3/24 at 10:00 p.m., 10/4/24 at 2:00 p.m. and 10:00 p.m., 10/7/24 at 2:00 p.m. and 10:00 p.m., 10/8/24 at 10:00 p.m., and 10/9/24 at 10:00 p.m. b. Her dicyclomine tablet (for irritable bowel), 20 mg was not given on 10/3/24 at 10:00 p.m., 10/4/24 at 10:00 p.m., 10/7/24 at 10:00 p.m., 10/8/24 at 10:00 p.m., 10/9/24 at 10:00 p.m., and 10/10/24 at 8:00 a.m. c. Her dorzolamide-timolol 2-0.5 % (treat glaucoma) was not given at 7:00 p.m. on 10/3/24, 10/4/24, 10/7/24, 10/8/24, and 10/9/24. d. Her hydrocodone-acetaminophen 10-325 mg, schedule II tablet (controlled substance) was not given on 10/3/24 at 10:00 p.m., 10/4/24 at 2:00 p.m. and 10:00 p.m., 10/7/24 at 2:00 p.m. and 10:00 p.m., 10/8/24 and 10/9/24 at 10:00 p.m.	F 0755	p="" paraid="504882855" paraeid="{e927744d-1fd4-4015-a9f4-98be15b27bdc}{81}">What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? Resident B is receiving medications per physician orders. p="" paraid="2068518277" paraeid="{e927744d-1fd4-4015-a9f4-98be15b27bdc}{103}"> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. A 1x audit completed for all resident medication administration record to ensure medications are being administered per MD order What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An in-service completed by DNS/designee on or before 10/31/24 with nursing staff regarding medication	11/01/2024

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	e. Her symbicort (budesonide-formoterol) aerosol inhaler was not given at 7:00 p.m. on 10/3/24, 10/4/24, 10/7/24 and 10/9/24. f. Her trazodone tablet (treats depression and anxiety) 100 mg was not given on 10/3/24, 10/4/24, 10/7/24, 10/8/24 and 10/9/24. g. Her albuterol inhaler was not given on 10/5/24 at 6:00 p.m. A current policy titled, "General Dose Preparation and Medication Administration," dated 4/30/24, was provided by the DON, on 10/10/24 at 11:30 a.m., A review of the policy indicated, " ...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident ...." This citation relates to Complaint IN00443579. 3.1-48(c)(1)		administration Medication administration record will be reviewed daily by DNS/designee to identify omissions and follow-up completed as needed p="" paraid="504882855" paraeid="{e927744d-1fd4-4015-a9f4-98be15b27bdc}{81}"> p="" paraid="2068518277" paraeid="{e927744d-1fd4-4015-a9f4-98be15b27bdc}{103}"> How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? **The DNS/Designee will be responsible for the completion of the Medication Storage / Self Medication Administration / Medication Administration and Prep Review CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director** **If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.**	

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observations, interviews, and record reviews, the facility failed to ensure all medications and treatments were stored and labeled properly for the facility in 1 of 1 medication storage rooms and 1 of 1 medication carts reviewed. This deficient practice had the potential to affect 78 of 78 residents that resided in the facility who received medications. Findings include: On 10/10/24 at 9:57 a.m., the medication storage room was observed with Director of Nursing (DON). The medication storage room was observed to have a large quantity of various medications and treatments which needed to be returned. The medications were stacked and scattered throughout the room. There were two full bins which overflowed on to the counter and floor and one sink was observed to be full of medications which overflowed into the second sink. The DON stated all the medications observed came off the medication carts this week. The DON indicated one bag of medication was mixed in with the to-be-returned to pharmacy medication and should not have been there. The DON indicated that the Medical Records Coordinator (MRC) was responsible for loading medication into the system to initiate the pharmacy return process. The medication refrigerator had Aplisol (an injectable solution to test for tuberculosis) with an arrival date of 7/29/24, with no open date. The DON indicated that she would dispose of it. On 10/10/2024 at 10:49 a.m., the B Hall medication cart was reviewed with Licensed Practical Nurse	F 0761	p="" paraid="1241141478" paraeid="{e927744d-1fd4-4015-a9f4-98be15b27bdc}{205}">What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The medications with no open date or label were immediately removed from the medication cart. Undated vial of was immediately removed from the medication room refrigerator and disposed of Medication storage room medication and treatments immediately labeled and stored properly How be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged practice. p="" paraid="274817672" paraeid="{46953e92-baf1-45c4-a2f0-395198c9df35}{10}">All medication carts and medication storage room were audited x1 to ensure all medications and treatments are stored and labeled properly What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	11/01/2024

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	155291	A. BUILDING 00 B. WING	10/10/2024

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	(LPN) 8. The medications reviewed were as follows: Resident B had brimonidine/ bromidine 0.2% (a type of eye drop) no open date, manufactures expiration date 04/2026. Medication to stay on cart until manufactures expiration date. Resident F had latanoprost 0.005% (a type of eye drop) with no open date, manufactures expiration date 12/2026. Resident G had latanoprost 0.005% with an open date of 7/1/24, manufacture expiration date 10/2026. During an interview, on 10/10/24 at 11:30 a.m., the DON indicated, eye drops need to have open dates. When asked about why the medication storage was in disarray, the DON indicated, the MCR had left the position on 8/9/2024. The their absence, the facility relied on a Float MRC, but they only came to the facility once every 2 weeks to fill in until they could fill the position. The DON indicated, the facility staff looked at orders, but did not scan them into the computer. They were a "paperless" facility and the DON expected the nursing staff to scan in documents as needed. During an interview on 10/11/24 at 3:08 p.m., the Float MRC indicated, he had only been at the facility a couple of times since the previous medical records person left on 8/9/24. No one from the building had requested him to return to the building. He indicated he scanned documents into the resident's electronic medical records and did nothing with medication storage or the medications that needed to be returned to the pharmacy. The facility would take care of the pharmacy returns. He was not made aware of the		DNS/designee will conduct an in-service with nurses on medication storage and labeling on or before 10/31/24 Medication carts and medication storage will be audited daily by DNS/designee to ensure all medications and treatments are labeled and stored properly. Any concerns will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will be responsible for the completion of the Medication Storage / Self Medication Administration / Medication Administration and Prep Review CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	

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	need to scan documents before they could be returned to the pharmacy. He indicated he did not have daily duties at the facility, he only did billing. On 10/10/24 at 11:30 a.m., the DON provided a copy of current facility policy titled, "Storage and Expiration Dating of Medications and Biologicals," dated 8/1/24. The policy indicated, " ...facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers, of sufficient size to prevent crowding ...facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier ...when an ophthalmic solution or suspension has a manufacture shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container ...." On 10/10/24 at 12:25 p.m., the DON provided a copy of current facility policy titled, "Returning Medications to the Pharmacy," dated 7/1/24. The policy indicated, " ...if returns are permitted under applicable law, facility should return medications with any associated paperwork or documentation to pharmacy immediately after such medications have been discontinued ...." This citation relates to Complaint IN00443579. 3.1-25(j) 3.1-25(m) 3.1-25(n)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to prevent the potential for the spread of a highly contagious virus when staff failed to perform hand hygiene and don personal protective equipment (PPE) in a COVID-19 positive isolation room for 2 of 2 days of observation. This deficient practice had the potential to effect 22 of 78 residents who resided on the D-hall of the facility. Findings include: During an interview on 10/9/24 at 11:36 a.m., Resident B indicated she was worried about catching COVID-19 because she knew staff were not using the appropriate PPE to enter isolation rooms. She indicated she often sat at the nurses station and watched as staff entered COVID-19 positive rooms and they did not put on a gown, gloves or new masks. On 10/9/24 at 1:30 p.m., Resident C's room was observed from the hallway. The door was open, but there was a bright red sign which indicated PPE was required to enter the room due to droplet isolation precautions. On 10/9/24 at 1:48 p.m., Certified Nursing Assistant (CNA) 6 entered Resident C's room. She did not perform hand hygiene, don a gown, gloves, N-95 or eye protection. She exited the room with a lunch tray, and carried the uncovered tray don't he hall, past the nurse station and down the hallway to the dining room where she placed the tray into a rolling cart. On 10/9/24 at 2:00 p.m., Resident C's room was	F 0880	p="" paraid="1482876069" paraeid="{46953e92-baf1-45c4-a2f0-395198c9df35}{142}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? CNA 6 and 7 for Resident C were immediately educated on donning appropriate PPE and hand washing for COVID-19 positive isolation room How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents on isolation precautions have the potential to be affected by the alleged deficient practice. An in-service will be completed by DNS/designee for all staff regarding proper infection control practice to include donning appropriate PPE and hand washing per policy for residents on isolation precautions on or before 10/31/24. p="" paraid="1428765143" paraeid="{46953e92-baf1-45c4-a2f0-395198c9df35}{230}"> What measures will be put into place or what systemic changes make to	11/01/2024

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	observed from the hallway. There was no waste basket for discarded PPE inside the room. On 10/10/24 at 8:58 a.m., CNA 6 and CNA 7 entered Resident C's room to provider her breakfast tray. Neither CNA performed hand hygiene, donned gowns, gloves, N-95s or eye protection. CNA 6 and 7 exited the room. Neither CNA performed hand hygiene before they continued to other resident's rooms to distribute breakfast trays. During an interview on 10/10/24 at 9:00 a.m., the Director of Nursing Services (DNS) indicated, all staff and visitors should don appropriate PPE and perform hand hygiene before entering a covid positive and/or any isolation room. The DNS immediately educated the two CNAs. On 10/9/24 at 1:28 p.m., Resident C's record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, vascular dementia (a degenerative brain disease which affects conitive function and memory) and a history of cancer. A nursing progress note, dated 10/2/24 at 10:19 a.m., indicated Resident C had complained of a sore throat. She was tested for COVID-19 and found to be positive. She was placed in isolation. During an interview on 10/10/24 at 11:07 a.m., the Infection Preventionist (IP) indicated, Resident C had been on Memory Care, but was moved to a room on the D-hall before staff knew she was positive. When residents on the memory care unit started to test positive, Resident C and her roommate were tested due to contact tracing. Resident C tested positive, but her roommate was negative. Resident C's roommate had not become		ensure that the deficient practice does not recur? An in-service will be completed by DNS/designee for all staff regarding proper infection control practice to include donning appropriate PPE and hand washing per policy for residents on isolation precautions on or before 10/31/24. Observational rounds will be completed daily by DNS/designee to ensure staff are proper PPE and performing hand hygiene per policy for residents on isolation precautions. p="" paraid="1428765143" paraeid="{46953e92-baf1-45c4-a2f0-395198c9df35}{230}">How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? p="" paraid="1428765143" paraeid="{46953e92-baf1-45c4-a2f0-395198c9df35}{230}"> The DNS/Designee will be responsible for the completion of the Infection Control Review CQI Tool for six months with audits being completed weekly x4 weeks then monthly x5 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director	

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	symptomatic and therefore had not been tested since her initial contact test. The IP indicated staff should perform hand hygiene before and after leaving any room and should follow all PPE precautions as indicated by the signs on the resident's doors. On 10/9/24 at 2:43 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Standard and Transmission-Based Precautions (Isolation) Policy," revised 4/2024. The policy indicated, " ...Purpose: to implement appropriate transmission-based precautions to prevent the transmission of infection ... Always assume that every resident is potentially infected or colonized with an organism that could be transmitted in the healthcare setting ... hand hygiene [should be completed] after touching resident surroundings (objects surfaces in the resident's environment) ... Covid-19 positive resident ... HCP [healthcare provider] should wear an N95 or higher-level respirator, eye protection ... gloves and gown when caring for these residents ... PPE must be appropriately doffed and discarded in trash prior to leaving room ...." This citation relates to Complaint IN00443579. 3.1-18(a)		If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action and/or including termination of the responsible employee.	